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W 000	INITIAL COMMENTS C #56536 Census- 298 Sample size- 4	W 000		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and review of facility incident reports, investigations, and medical records, it was determined that the facility failed to ensure appropriate interventions to protect 1 of 4 sampled consumers from neglect while under staff monitoring for injuries and treatment related to a left 5th finger fracture. Findings include: 1. Consumer #1 was profoundly mentally retarded and totally dependent upon staff for all care needs. This consumer had sustained a fracture of the left 5th finger identified on 4/19/12 and underwent application of a fiberglass splint and ace wrap on the same date. Post treatment Orthopedic orders specified nursing checks as per facility orthopedic check sheet. Although nursing documentation from 4/19-4/26/12 indicated that color, temperature, sensation, edema and pulse were assessed, no evidence was found that the ace wrap and splint were removed to fully visualize and/or comprehensively assess the affected extremity. On 4/27/12 a follow-up Orthopedic consult identified the	W 122		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 122	Continued From page 1 consumer's hand to be necrotic and mummified, necessitating emergency hospitalization and consultation with a vascular surgeon. On 5/11/12 a complete distal forearm amputation was performed. Pre and Postoperative diagnoses were documented as gangrene of the left hand and wrist. (Cross Reference W149)	W 122		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and review of facility investigations, incident reports, medical records and facility documents, it was determined that the facility failed to follow its policy on Abuse/Neglect for 1 of 4 sampled Consumers (Consumer #1.) Consumer #1 was profoundly mentally retarded and totally dependent upon staff for all care needs. This consumer had sustained a fracture of the left 5th finger identified on 4/19/12 and underwent application of a fiberglass splint and ace wrap on the same date. Post treatment Orthopedic orders specified nursing checks as per facility orthopedic check sheet. Although nursing documentation from 4/19-4/26/12 indicated that color, temperature, sensation, edema and pulse were assessed, no evidence was found that the ace wrap and splint were removed to fully visualize the affected extremity. On 4/27/12 a follow-up Orthopedic consult identified the consumer's hand to be necrotic and mummified, necessitating emergency hospitalization and consultation with a vascular	W 149		

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W 149	Continued From page 2 surgeon. On 5/11/12 a complete distal forearm amputation was performed. Pre and Postoperative diagnoses were documented as gangrene of the left hand and wrist. The Facility policy entitled Abuse/Neglect states that the facility does not tolerate any form of abuse, mistreatment or neglect, and ensures that consumer protections are in place. Specifically, the following from the policy is noted: IV. Definitions B. "NEGLECT is the failure of an employee to provide for or maintain the care of those under his or her supervision, including provision of services and supports required to ensure the health, safety and welfare of an individual or to otherwise fail to fulfill his or her duty."	W 149		
W 318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interview and review of facility incident reports, investigations, and medical records, it was determined that the facility failed to effectively/comprehensively assess, monitor, and report a significant, progressive decline in condition for 1 of 4 sampled consumers (Consumer #1) who was profoundly mentally retarded and totally dependent upon staff for all care needs. This consumer had sustained a fracture of the left 5th finger identified on 4/19/12 and underwent application of a fiberglass splint	W 318		

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W 318	Continued From page 3 and ace wrap on the same date. Post treatment Orthopedic orders specified nursing checks as per facility orthopedic check sheet. Although nursing documentation from 4/19-4/26/12 indicated that color, temperature, sensation, edema and pulse were assessed, no evidence was found that the ace wrap and splint were removed to fully visualize the affected extremity. On 4/27/12 a follow-up Orthopedic consult identified the consumer's hand to be necrotic and mummified, necessitating emergency hospitalization and consultation with a vascular surgeon. On 5/11/12 a complete distal forearm amputation was performed. Pre and Postoperative diagnoses were documented as gangrene of the left hand and wrist. This deficient practice is evidenced by the following: 1. The facility failed to ensure that nursing services were provided in accordance with consumer needs (Cross Reference W 331.) 2. The facility staff failed to conduct a direct physical examination and/or a thorough visual review of the affected extremity as per physician's orders (Cross Reference W 334.)	W 318		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on interview and review of facility medical records, incident reports, and investigations it was determined that the facility failed to	W 331		

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W 331	Continued From page 4	W 331		

effectively and/or comprehensively assess, monitor, and report a significant, progressive decline in condition for 1 of 4 sampled consumers (Consumer #1) who was to receive comprehensive orthopedic checks by nursing staff. A follow-up orthopedic consult identified the consumer's hand to be necrotic and mummified, necessitating emergency hospitalization and a subsequent complete distal forearm amputation. Pre and Postoperative diagnoses were gangrene of the left hand and wrist. This deficient practice is evidenced by the following:

1. Consumer #1 was admitted to the facility on 1/3/63 and had diagnoses including but not limited to profound mental retardation, microcephaly, and Pica (eating non-food items.) A 12/8/11 annual Individual Habitation Plan meeting note indicates the consumer was nonverbal and unable to convey needs; totally dependent upon staff for all care; impulsive and grabbing/taking what was desired, and unable to make rational decisions or choices. The consumer resided in Sykes cottage.

Surveyor review of medical records on 5/17/12 revealed the following regarding Consumer #1:

On 4/2/12, during care at 1:45 A.M., a Human Services Assistant (HSA) observed edema and ecchymosis of the consumer's left hand pinky finger. The Cottage Training Supervisor (CTS) and Nurse were notified and a nursing assessment was conducted. The physician was notified, and the consumer was transported to the Emergency Room (ER). An X-ray was taken of the involved finger and was negative for fracture. The discharge diagnosis was "contusion of the

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left 5th finger". The consumer returned to the facility, was provided with Tylenol for pain, and continued with usual activities including self-propelling the wheelchair for short distances.

On 4/18/12 a nursing re-assessment of the left 5th finger revealed continued moderate swelling with faded bruising, and active range of motion (ROM) without obvious pain. The physician was notified of the continued symptoms and conducted an examination. A repeat X-ray was ordered to rule out a missed fracture, and an orthopedic consult was requested.

An X-ray was completed on 4/19/12. Results revealed a comminuted fracture of the base of the middle phalanx of the left 5th finger, with fracture line extending to the interphalangeal joint and subluxation of the interphalangeal joint. The consumer was transported to the ER for further evaluation, and was subsequently discharged with an ulnar gutter splint applied to the left forearm and a sling to the left arm. Upon return to the facility, enhanced (1:1) supervision was implemented to "prevent self injury."

Facility investigation of this injury of unknown origin concluded the injury had likely "occurred when her finger came in contact with an object in her immediate environment." Additionally noted was that the consumer "has full motion of her hands and will grab and take what she wants without regard to others and is impulsive."

Review of Active Treatment (AT) notes reveal that on the evening of 4/19/12, the consumer was attempting to pull on the cast and staff were concerned for Pica risk.

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Although 1:1 supervision was initiated, documentation indicates that at 9:15 PM the consumer succeeded in removing the splint. A Registered Nurse (RN) assessment was completed with no resultant trauma noted. The splint was reapplied by the RN. Nursing entries indicate the resident continued to bite or pull on the bandage, and a nursing entry of 4/20/12 at 8 AM states "splint/wrap reapplied."

On 4/20/12 at 9:20 A.M. the consumer was transferred to the C-wing/clinic area of the facility, for increased medical monitoring and supervision. She was evaluated by the physician with new orders for enhanced supervision (1:1) x 30 days; maintain half cast/splint to the left hand and keep clean and dry, replace ace wrap as needed; routine ortho checks per policy, and left arm sling when out of bed.

Subsequent AT notes from 4/20/12 through 4/27/12 continue to note staff providing Tylenol for pain with varying degrees of effectiveness, and the consumer's increasing attempts to remove the splint/bandages including the following:

4/22/12 11:45 P.M.: bluish discoloration of 3rd & 4th phalanx tips observed; consumer chews on splint; "maybe some type of covering on the splint will help with redirecting."

4/23/12 10:20 P.M.: "attempted to remove ace bandage, another one applied."

4/25/12 6:33 A.M.: "has been up all night sitting up and trying to [take her bandage] (sic)

4/27/12 6:30 A.M.: "awake until 2:00 A.M.....

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needed ongoing redirection from removing her soft cast."

On 4/27/12 at 5 P.M., the consumer was seen by the orthopedist for re-evaluation. The re-evaluation was conducted on site in the C-wing clinic area. The related AT entry reflects that upon removal of the splint, the consumer's left hand was noted to be discolored and necrotic. Facility administrative, medical, and investigative staff and the consumer's guardian were notified. The orthopedist applied a new soft splint permitting fingers exposed. The consumer was transported to the hospital and admitted for vascular surgical evaluation and treatment.

The surveyor reviewed a Nursing Services Orthopedic Check Sheet for Consumer #1, for the dates of 4/19/12 at 5 PM through 4/27/12 at 9:15 AM. This document notes an affected extremity of the left 5th finger, and the presence of a splint and ace wrap. The document additionally indicates that nursing assessments of the affected extremity were completed, specifically regarding color, temperature, sensation, motion, edema, and pulse, with applicable comments. Nursing documentation for the applicable time period indicate skin color consistently pink, skin temperature warm, sensation and motion present, and pulse present. Nursing comments consistently note the presence of a splint and/or ace wrap, and that it was dry and intact. An entry on 4/19/12 at 9:15 [sic] states the splint was removed by the consumer. An entry on 4/20/12 at 2:30 AM indicates the splint/ace wrap was intact. An entry on 4/20/12 at 8 AM indicates the splint and wrap was reapplied.

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A 4/23/12 second shift C-Wing Nursing Shift Log/Health Matters document was reviewed by the surveyor. An entry at 8:10 PM notes that Consumer #1 "attempted to remove ace bandage (Rewrapped with newer ace bandage) instructed 1 on 1 to please keep an eye on her- that's why she has enhanced supervision."

A subsequent entry on the Shift Log on 4/27/12 at 6:45 PM indicates the consumer was "Sent to ER..... necrotic pinky and 4th digit. Mummified left hand. (Discoloration to left hand)... " [sic]

The facility generated an "Unusual Incident Report" regarding occurrence date 4/27/12 at 5:06 PM. The report reflects the following:
Category: neglect
Specific Incident Type: major injury
Date/time of occurrence: not known
Description of incident: On 4/27/12 at approximately 5:06 PM the consumer was seen in the facility orthopedic clinic by the Orthopedist for initial follow-up regarding a displaced comminuted fracture at the proximal end of the middle phalanx of the left 5th finger.
Upon evaluation, it was identified "that the ace wrap that was applied to the left hand was extremely tight. The ace wrap was removed with acute necrosis noted to the left hand."

On 4/30/12 a Registered Nurse from the orthopedic consultation clinic located within the facility notified the Office of Investigation (OI) of the situation, and "that the ace wrap applied to the consumer's left hand was applied so tightly that she could possible have digits to that extremity amputated."

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W 331	Continued From page 9 The following interviews were conducted by the surveyor on 5/17/12 unless noted otherwise: At 10:35 AM the Executive Director (ED) stated that pending investigation by the Investigative Response Team (IRT,) the C wing (infirmary) had been closed since 5/9/12 and all nursing staff involved with care to Consumer #1 on C Wing were placed off duty. This included approximately 37-38 staff including part-time and contracted agency staff. The approximately 8 consumers present in C Wing at the time of closing were moved to alternate cottages. At 12:30 PM during discussion of procedure expectations regarding nursing orthopedic checks, the Director of Nursing (DON) stated that in order to accurately and comprehensively assess status via visual nursing checks, the ace bandage and splint should have been removed by the nurse during each assessment. The assessments are to be completed by RN's as per the facility Nursing Services Directive, a copy of which is available at the nurse's station of each cottage, in the clinic, the RN offices and the DON's office. Nurses are oriented to the use of the Directives upon initial orientation. Each Directive is reviewed by the DON and supervising RN's at least annually, with any changes communicated to cottage/unit staff by the supervising RN's. The following interviews were conducted by the surveyor on 5/22/12: During an interview with the surveyor in the Wycoff Building clinic area at 10:55 AM, the	W 331		

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Orthopedic surgeon stated that upon assessing Consumer #1 in the orthopedic clinic (on 4/27/12) he had observed the affected left hand to be tightly wrapped with 4-5 ace bandages, with no fingers exposed. The bandage "was wrapped so tight only God could have removed it." Upon removal of the bandages, the splint was observed to be improperly placed; the hand was "mummified" with no hydration present, and "clearly gangrenous" with odor present. The palm was "blown up" with a large blister present, draining and infected. He further noted that the bandages were wrapped improperly by staff, even if they had the best of intentions to prevent the consumer from removing the splint/bandages. In discussing the staff documentation of normal parameters on the Orthopedic Check Sheet and the clearly abnormal condition noted on 4/27/12, the orthopedic surgeon indicated that the records would indicate they were falsified.

At 11:45 AM the surveyor interviewed the lead IRT investigator/ Quality Assurance Coordinator regarding the IRT findings to date. The surveyor was advised that the investigation was still in progress; however findings to date were clear that the Licensed Practical Nurses (LPN's) responsible for conducting the orthopedic checks "didn't do what they should have done." It was noted that during staff interviews, many direct care staff (HSA's- Human Services Assistants) had reported they were unable to see the consumer's fingers at all as the bandages were covering them. Some LPN's did not know what was wrong with the consumer's hand or why the bandages were present, and some thought she had surgery.

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W 331	Continued From page 11 The IRT investigator noted that no nursing reference/Plan of Care for the consumer was found. Additionally, it was identified that the consumer was scheduled to be seen in the Orthopedic Clinic for follow-up 2 days prior to when actually seen on 4/27/12, however an RN had taken her off the schedule. Investigative interviews had also determined that no nurse's in C -Wing had totally removed the bandages for assessment since 4/21/12, and only kept putting on more ace wraps. The nurses admitted they were unable to see the consumer's fingers due to the bandages, and the orthopedic surgeon had indicated it was necessary for him to cut the bandages off. It was additionally noted that information regarding the consumer's status was not effectively communicated by nursing staff from shift to shift. The facility Nursing Services Directive, titled Documentation, issued 9/01 and revised 9/11 includes the following regarding complete nursing assessment: "VI. Directive: Section L. regarding C Wing Infirmary Patients 1. Documentation in the IHP6 notes must include: (a) Objective data relevant to the presenting problem. (b) A Plan of Care that includes identified nursing problems with appropriate interventions." The surveyor reviewed Consumer #1's related hospital records from South Jersey Healthcare System including but not limited to:	W 331		

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W 331	Continued From page 12 Emergency Department Nursing Notes, 4/27/12 Diagnosis: acute left hand necrosis status post recent fracture Triage Assessment at 19:32: "...fingers left pinky blue to black, ring finger also blue to black in color. Other fingers on that hand are whitish in color, ecchymosis noted on the whole hand, on the plantar surface as well. Left pinky swollen.... Indentations noted across the fingers on the distal aspects." History and Physical, dictated on 4/27/12 at 23:26: Extremities: "... Physical examination of left upper extremity reveals an ecchymotic and blistered left hand that appears to be necrotic and avascular. There is no palpable radial or ulnar pulse at this time. Capillary refill reveals no return. There are blisters to both palmar as well as dorsal hand, with diffuse ecchymosis with wasting of the index finger consistent with necrosis of the left hand from the proximal wrist crease distally...." Operative Report 5/11/12, dictated on 5/15/12 at 11:41: "Preoperative Diagnosis; Gangrene, left hand and wrist Postoperative Diagnosis: Gangrene, left hand and wrist Treatment: Complete distal forearm amputation, above level of proximal to radial styloid and ulnar styloid." Surgical Pathology Report 5/11/12: "Diagnosis: Left upper extremity (distal forearm amputation): Gangrene of hand."	W 331		
W 334	483.460(c)(3)(i) NURSING SERVICES	W 334		

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W 334	Continued From page 13 Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be by a direct physical examination. This STANDARD is not met as evidenced by: NJ 56536 Based on interview and review of facility medical records, incident reports, and investigations, it was determined that the facility failed to effectively and/or comprehensively visually assess, monitor, and report a significant, progressive decline in condition for 1 of 4 sampled consumers (Consumer #1) who was to receive comprehensive orthopedic checks by nursing staff. A follow-up orthopedic consult identified the consumer's hand to be necrotic and mummified, necessitating emergency hospitalization and a subsequent complete distal forearm amputation. Pre and Postoperative diagnoses were gangrene of the left hand and wrist. This deficient practice is evidenced by the following: 1. Consumer #1 was admitted to the facility on 1/3/63 and had diagnoses including but not limited to profound mental retardation, microcephaly, and Pica (eating non-food items.) A 12/8/11 annual Individual Habitation Plan meeting note indicates the consumer was nonverbal and unable to convey needs; totally dependent upon staff for all care; impulsive and grabbing/taking what was desired, and unable to make rational decisions or choices. The consumer resided in	W 334		

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Sykes cottage.

Surveyor review of medical records on 5/17/12 revealed the following regarding Consumer #1:

On 4/2/12 during care at 1:45 A.M. a Human Services Assistant (HSA) observed edema and ecchymosis of the consumer's left hand pinky finger. The Cottage Training Supervisor (CTS) and Nurse were notified and a nursing assessment was conducted. The physician was notified, and the consumer was transported to the Emergency Room (ER). An X-ray was taken of the involved finger which was negative for fracture. The discharge diagnosis was contusion of the left 5th finger. The consumer returned to the facility, was provided with Tylenol for pain, and continued usual activities including self-propelling the wheelchair for short distances.

On 4/18/12, a nursing re-assessment of the left 5th finger revealed continued moderate swelling with faded bruising, and active range of motion (ROM) without obvious pain. The physician was notified of the continued symptoms and conducted an examination. A repeat X-ray was ordered to rule out a missed fracture, and an orthopedic consult was requested.

An X-ray was completed on 4/19/12. Results revealed a comminuted fracture of the base of the middle phalanx of the left 5th finger, with fracture line extending to the interphalangeal joint and subluxation of the interphalangeal joint. The consumer was transported to the ER for further evaluation, and was subsequently discharged with an ulnar gutter splint applied to the left forearm and a sling to the left arm. Upon return to

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the facility, enhanced (1:1) supervision was implemented to "prevent self injury."

Facility investigation of this injury of unknown origin concluded the injury had likely "occurred when her finger came in contact with an object in her immediate environment." Additionally noted was that the consumer "has full motion of her hands and will grab and take what she wants without regard to others and is impulsive."

Review of Active Treatment (AT) notes reveal that on the evening of 4/19/12, the consumer was attempting to pull on the cast and staff were concerned for Pica risk.
Although 1:1 supervision was initiated, documentation indicates that at 9:15 PM the consumer succeeded in removing the splint. A Registered Nurse (RN) assessment was completed with no resultant trauma noted. The splint was reapplied by the RN. Nursing entries indicate the resident continued to bite or pull on the bandage, and a nursing entry of 4/20/12 at 8 AM states "splint/wrap reapplied."

On 4/20/12 at 9:20 A.M., the consumer was transferred to the C-wing/clinic area of the facility, for increased medical monitoring and supervision. She was evaluated by the physician with new orders for enhanced supervision (1:1) x 30 days; maintain half cast/splint to the left hand and keep clean and dry, replace ace wrap as needed; routine ortho checks per policy, and left arm sling when out of bed.

Subsequent AT notes from 4/20/12 through 4/27/12 continue to note staff providing Tylenol for pain with varying degrees of effectiveness, and

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the consumer's increasing attempts to remove the splint/bandages including the following:

4/22/12 11:45 P.M.: bluish discoloration of 3rd & 4th phalynx tips observed; consumer chews on splint; "maybe some type of covering on the splint will help with redirecting."

4/23/12 10:20 P.M.: "attempted to remove ace bandage, another one applied."

4/25/12 6:33 A.M.: "has been up all night sitting up and trying to [take her bandage] (sic)

4/27/12 6:30 A.M.: "awake until 2:00 A.M..... needed ongoing redirection from removing her soft cast."

On 4/27/12 at 5 P.M., the consumer was seen by the orthopedist for re-evaluation. The re-evaluation was conducted on site in the C-wing clinic area. The related AT entry reflects that upon removal of the splint, the consumer's left hand was noted to be discolored and necrotic. Facility administrative, medical, and investigative staff and the consumer's guardian were notified. The orthopedist applied a new soft splint permitting fingers exposed. The consumer was transported to the hospital and admitted for vascular surgical evaluation and treatment.

The surveyor reviewed a Nursing Services Orthopedic Check Sheet for Consumer #1, for the dates of 4/19/12 at 5 PM through 4/27/12 at 9:15 AM. This document notes an affected extremity of the left 5th finger, and the presence of a splint and ace wrap. The document additionally indicates that nursing assessments of the

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affected extremity were completed, specifically regarding color, temperature, sensation, motion, edema, and pulse, with applicable comments. Nursing documentation for the applicable time period indicate skin color consistently pink, skin temperature warm, sensation and motion present, and pulse present. Nursing comments consistently note the presence of a splint and/or ace wrap, and that it was dry and intact. An entry on 4/19/12 at 9:15 [sic] states the splint was removed by the consumer. An entry on 4/20/12 at 2:30 AM indicates the splint/ace wrap was intact. An entry on 4/20/12 at 8 AM indicates the splint and wrap was reapplied.

A 4/23/12 second shift C-Wing Nursing Shift Log/Health Matters document was reviewed by the surveyor. An entry at 8:10 PM notes that Consumer #1 "attempted to remove ace bandage (Rewrapped with newer ace bandage) instructed 1 on 1 to please keep an eye on her- that's why she has enhanced supervision."

A subsequent entry on the Shift Log on 4/27/12 at 6:45 PM indicates the consumer was "Sent to ER..... necrotic pinky and 4th digit. Mummified left hand. (Discoloration to left hand)... " [sic]

The facility generated an "Unusual Incident Report" regarding occurrence date 4/27/12 at 5:06 PM. The report reflects the following:
Category: neglect
Specific Incident Type: major injury
Date/time of occurrence: not known
Description of incident: On 4/27/12 at approximately 5:06 PM the consumer was seen in the facility orthopedic clinic by the Orthopedist

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for initial follow-up regarding a displaced comminuted fracture at the proximal end of the middle phalynx of the left 5th finger.
Upon evaluation, it was identified "that the ace wrap that was applied to the left hand was extremely tight. The ace wrap was removed with acute necrosis noted to the left hand."

On 4/30/12, a Registered Nurse from the orthopedic consultation clinic notified the Office of Investigation (OI) of the situation, and "that the ace wrap applied to the consumer's left hand was applied so tightly that she could possibly have digits to that extremity amputated."

The following interviews were conducted by the surveyor on 5/17/12 unless noted otherwise:

At 10:35 AM the Executive Director (ED) stated that pending investigation by the Investigative Response Team (IRT,) the C wing (infirmary) had been closed since 5/9/12 and all nursing staff involved with care to Consumer #1 on C Wing were placed off duty. This included approximately 37-38 staff including part-time and contracted agency staff. The approximately 8 consumers present in C Wing at the time of closing were moved to alternate cottages.

At 12:30 PM during discussion of procedure expectations regarding nursing orthopedic checks, the Director of Nursing (DON) stated that in order to accurately and comprehensively assess status via visual nursing checks, the ace bandage and splint should have been removed by the nurse during each assessment. The assessments are to be completed by RN's as per the facility Nursing Services Directive, a copy of

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which is available at the nurse's station of each cottage, in the clinic, the RN offices and the DON's office. Nurses are oriented to the use of the Directives upon initial orientation. Each Directive is reviewed by the DON and supervising RN's at least annually, with any changes communicated to cottage/unit staff by the supervising RN's.

The following interviews were conducted by the surveyor on 5/22/12:

During an interview with the surveyor in the Wycoff Building clinic area at 10:55 AM, the Orthopedic surgeon stated that upon assessing Consumer #1 in the orthopedic clinic (on 4/27/12) he had observed the affected left hand to be tightly wrapped with 4-5 ace bandages, with no fingers exposed. The bandage "was wrapped so tight only God could have removed it." Upon removal of the bandages, the splint was observed to be improperly placed, the hand was "mummified" with no hydration present, and "clearly gangrenous" with odor present. The palm was "blown up" with a large blister present, draining and infected. He further noted that the bandages were wrapped improperly by staff, even if they had the best of intentions to prevent the consumer from removing the splint/bandages. In discussing the staff documentation of normal parameters on the Orthopedic Check Sheet and the clearly abnormal condition noted on 4/27/12, the orthopedic surgeon indicated that the records would indicate they were falsified.

At 11:45 AM the surveyor interviewed the lead IRT investigator/ Quality Assurance Coordinator regarding the IRT findings to date. The surveyor

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was advised that the investigation was still in progress, however findings to date were clear that the Licensed Practical Nurses (LPN's) responsible for conducting the orthopedic checks "didn't do what they should have done." It was noted that during staff interviews, many direct care staff (HSA's- Human Services Assistants) had reported they were unable to see the consumer's fingers at all as the bandages were covering them. Some LPN's did not know what was wrong with the consumer's hand or why the bandages were present, and some thought she had surgery.

The IRT investigator noted that no nursing reference/Plan of Care for the consumer was found. Additionally, it was identified that the consumer was scheduled to be seen in the Orthopedic Clinic for follow-up 2 days prior to when actually seen on 4/27/12, however an RN had taken her off the schedule. Investigative interviews had also determined that no nurse's in C -Wing had totally removed the bandages for assessment since 4/21/12, and only kept putting on more ace wraps. The nurses admitted they were unable to see the consumer's fingers due to the bandages, and the orthopedic surgeon had indicated it was necessary for him to cut the bandages off.

It was additionally noted that information regarding the consumer's status was not effectively communicated by nursing staff from shift to shift.

The facility Nursing Services Directive, titled Documentation, issued 9/01 and revised 9/11 includes the following regarding complete nursing

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W 334	Continued From page 21 assessment: "VI. Directive: Section L. regarding C Wing Infirmary Patients 1. Documentation in the IHP6 notes must include: (a) Objective data relevant to the presenting problem. (b) A Plan of Care that includes identified nursing problems with appropriate interventions." The surveyor reviewed Consumer #1's related hospital records from South Jersey Healthcare System including but not limited to: Emergency Department Nursing Notes, 4/27/12 Diagnosis: acute left hand necrosis status post recent fracture Triage Assessment at 19:32: "...fingers left pinky blue to black, ring finger also blue to black in color. Other fingers on that hand are whitish in color, ecchymosis noted on the whole hand, on the plantar surface as well. Left pinky swollen.... Indentations noted across the fingers on the distal aspects." History and Physical, dictated on 4/27/12 at 23:26: Extremities: "... Physical examination of left upper extremity reveals an ecchymotic and blistered left hand that appears to be necrotic and avascular. There is no palpable radial or ulnar pulse at this time. Capillary refill reveals no return. There are blisters to both palmar as well as dorsal hand, with diffuse ecchymosis with wasting of the index finger consistent with necrosis of the left hand from the proximal wrist crease distally...."	W 334		

State of New Jersey
DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 367
TRENTON, N.J. 08625-0367

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CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

MARY E. O'DOWD, M.P.H.
Commissioner

June 6, 2012

Eloise Hawkins

Vineland Developmental Center
1676 East Landis Ave
Vineland, NJ 08360

Dear Ms. Hawkins:

Thank you for the courtesy and cooperation extended during our visit to your facility on May 22, 2012 regarding complaint Complaint # NJ 56536. By our observation and evaluation based on the regulations, certain deficiencies were evident at that time. A plan of correction must be submitted within 10 days of receipt of the statement of deficiencies (CMS). Your plan of correction must contain the following information:

- the corrective actions that specifically address the individuals affected by the deficient practice, with the date by which these actions will be accomplished entered into the right hand column of the CMS 2567;

- the method to identify other individuals who are potentially affected by the deficient practice, with the date by which these changes will be implemented entered into the right hand column of the CMS 2567;

- the systemic changes instituted which will ensure that the deficient practice is corrected and will not recur, with the date by which these changes will be implemented entered into the right hand column of the CMS 2567; and

- the quality improvement system through which the effectiveness of the changes is monitored and evaluated, the schedule for evaluation, and the person(s) responsible for these procedures.

Please sign and date the enclosed CMS 2567's once the facility's plan of correction has been entered and return to this office.

To verify that correction of the deficiencies cited on May 22, 2012 has occurred, a revisit survey may be conducted. If correction has not been achieved at the time of the revisit survey, the Long Term Care Systems, Assessment and Survey Program may recommend imposition of appropriate penalties for continued noncompliance.

If you have any questions regarding the contents of this letter, please contact me at 609-633-8991.

Sincerely,

Ann Korab RN
Health Care Services Evaluator/Nurse
Complaints & Surveillance

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W 000	INITIAL COMMENTS COMPLAINT # NJ000053935 CENSUS: 312	W 000		
W 102	SAMPLE SIZE: 9 483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and review of facility incident reports, investigations and medical records, it was determined that the governing body failed to adequately investigate, supervise, monitor and revise as necessary, interventions to protect all consumers residing in Wyckoff Cottage (current census of 36) from physical abuse (skin scratches/carvings) by an unidentified person(s) over a period of twenty-two months. This deficient practice is evidenced by the following: 1. The governing body failed to ensure that consumers were not subjected to physical abuse. (Cross Reference W127) These findings were cause for immediate jeopardy identified on 2/06/12. The immediate jeopardy was abated on the afternoon of 2/06/12 with receipt of an acceptable plan of correction. 2. The governing body failed to thoroughly	W 102	1. As noted in the Statement of Deficiencies W 102 refer to the plan of Correction dated February 6, 2012 that was accepted and abated. 2. Refer to W 127 Cross Referenced in the Statement of Deficiencies for Specific, Identification of Others, Systemic and Quality Assurance Responses.	2/6/2012

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W 102	Continued From page 1 investigate all reported skin scratchings/carvings of unknown origin. (Cross Reference W154) These findings were cause for immediate jeopardy identified on 2/06/12. The immediate jeopardy was abated on the afternoon of 2/06/12 with receipt of an acceptable plan of correction. 3. The governing body failed to protect consumers during the investigation process. (Cross Reference W155) These findings were cause for immediate jeopardy identified on 2/06/12. The immediate jeopardy was abated on the afternoon of 2/06/12 with receipt of an acceptable plan of correction. 4. The governing body failed to take appropriate actions to prevent recurrence of similar injuries of unknown origin over a period of nineteen months. (Cross Reference W157)		3.Refer to W 155 Immediate Jeopardy: refer to the Plan of Correction provided February 6, 2012. 4. Refer to W 157 Cross Referenced in the Statement of Deficiencies for Specific, Identification of Others, Systemic and Quality Assurance Responses.	3/14/2012
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on observation, interview and review of facility incident reports, investigations and medical records, it was determined that the facility failed to initiate appropriate interventions to protect all consumers residing in Wyckoff Cottage (Current Census of 36) from physical abuse after multiple incidents of skin scratching/carvings were reported. The unexplained injuries involved a total of eleven consumers over a period of	W 122	As noted in the Statement of Deficiencies refer to the Plan of Correction dated February 6, 2012 that was accepted and abated. Refer to W 127, Cross Referenced in this citation for Specific, Identification of Others, Systemic and Quality Assurance Responses.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATAURE TITLE (X6) DATE

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W 122	Continued From page 2 twenty –two months. Findings include: 1. Failure to ensure that all consumers residing in Wyckoff Cottage were not physically abused after multiple incidents of skin scratchings/carvings were reported. (Cross Reference W 127) These findings were cause for immediate jeopardy identified on 2/06/12. The immediate jeopardy was abated on the afternoon of 2/06/12 with receipt of an acceptable plan of correction. Failure to thoroughly investigate multiple reports of skin scratchings/carvings over a period of nineteen months two years. (Cross Reference W154) These findings were cause for an immediate jeopardy identified on 2/06/12. The immediate jeopardy was abated on the afternoon of 2/06/12 with receipt of an acceptable plan of correction. Failure to implement measures to prevent further abuse while the investigation was in process. (Cross Reference W155) These findings were cause for an immediate jeopardy identified on 2/06/12. The immediate jeopardy was abated on the afternoon of 2/06/12 with receipt of an acceptable plan of correction. Failure to implement appropriate corrective action to assure further related injuries would not occur. (Cross Reference W 157)	W 122		3/14/2012
W 127	483.420(a)(5) PROTECTION OF CLIENTS	W 127	**Specific #1: Consumer #2 IB** from Wyckoff Cottage was identified with unusual skin scratches on 11/2/2010 and was moved to another area in the facility for her protection. Appropriate treatment was provided for IB when identified. Based on the incident of 11/2/10 involving IB, the following measures were put in place: --IB was transferred from the cottage for	

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W 127	Continue From page 3 RIGHTS The Facility must ensure the rights of all clients. Therefore, the facility must nsure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: IMMEDIATE JEOPARDY Based on observation, interview and review of facility incident reports, investigations, and medical records, it was determined that the facility failed to ensure that consumers residing in Wyckoff Cottage (current census of 36) received adequate supervision and/or monitoring to prevent abuse after a pattern of unexplained injuries of unknown origin involving eleven consumers occurred over a twenty-two month period (January 14, 2010 through November 21, 2011). Subsequently, formal facility investigations for three of those eleven consumers (Consumers #1, 2, and 3) were validated as abuse. This deficient practice is evidenced by the following. 1. According to a facility investigative report initiated 11/2/2010) at 8:45 a.m., the assigned investigator (Investigator #1) documented that the Administrator On Duty (AOD) reported that sampled Consumer #2 residing in Wyckoff Cottage was found with multiple jagged scratches on her chest. The scratches were "suspicious" and appeared to be sustained within the last eight hours. At the time, the AOD also reported that two other consumers had sustained similar scratches about two weeks ago on their backs. The AOD then informed the investigator that she	W 127	her protection, staff from the cottage were not allowed to have any contact with the involved consumer. --Cottage rounds were increased by managerial staff. --After the subsequent incident of 3/29/11, an additional proactive measure was added to include managerial staff on site in the cottage. All above mentioned measures were kept in place until July, 2011, at which time there were no further incidents of this nature. The additional measures were re-started to ensure consumer protection following the incident of 11/21/11, which included --Removing the consumer from Wyckoff cottage. Wyckoff staff were not allowed to have any contact with the removed consumers --One employee in question was placed off duty, cleared and returned. --The Office of Investigation and the HSPD were informed and an investigation was initiated. --In the cases where issues were identified that required corrective actions, although not an allegation of abuse, disciplinary action was issued. --The employee who was cleared following the investigation was sent for retraining as deemed necessary	3/14/2012

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W127	Continued From page 4 could not rule out abuse. As a result, the caregiver assigned to the consumer was put off duty. The investigator's summary of evidence indicated Consumer #2 was ambulatory, non-verbal and functioned at the mentality level of an eleven month old. Her diagnoses included Profound Mental Retardation (PMR), Idiopathic Thrombocytopenia Purpura, Spastic Paraparesis, Scoliosis, and Osteoporosis. The consumer had a history of self injurious behavior that include slapping herself in the face or mouth, which did not usually cause any issues. The investigator then documented that she observed the consumer's environment and equipment on the unit and could not identify anything that would have caused the "suspicious scratches that looked like XXII." Due to the AOD's report of other consumers having similar injuries, the investigator reviewed all incident reports for the year 2010 and found ten additional consumers in Wyckoff Cottage with unexplained scratching injuries. Eight of those injuries were discovered on the late shift (10:45 p.m. – 6:45 a.m.). The investigator went to Wyckoff Cottage on 11/04/2010 to observe and photograph any visible marks on the consumers. Three consumers were photographed with similar healing criss-cross marks (sampled Consumers #4, 5 and 6). All three if these consumers had PMR, were non-verbal and unable to self report. The investigation summary indicated the investigator was unable to determine what or who caused the injury but abuse was validated.	W 127		3/14/2012

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W 127	Continued From page 5 An Addendum dated 12/07/10 indicated the Executive Incident Management (EIM) team recommended increased supervisory rounds in Wyckoff Cottage. All scratches reported by Wyckoff Cottage would be closely reviewed at the Local Incident Management (LIM) meetings. On 12/14/2010, Consumer #2 was moved to another cottage. 2. According to a facility Investigative Report initiated 3/28/11, at 1:45 p.m. that same day, the AOD reported that Consumer #3 was found with suspicious marks on her back that looked like Consumer #2's marks. The investigator (Investigator #2) immediately went to the cottage and viewed thew injury with the physician. Three were seven red, raised scratches, "suspicious in appearance." They varied in length from 9cm to 22 cm. The consumer had bilateral upper extremity contractures and the investigator determined it was not possible for the scratches to be self-inflicted, due to the consumer's contractures. An investigative Summary of Evidence indicated that Consumer #3 is dependent on staff for all activities of daily living and unable to self report. Her diagnoses include History of a Right Shoulder Fracture, Personality Change, Bipolar Osteoporosis, Blindness and Hypothyroidism. The consumer received her nutrition via PEG tube. The investigation conclusion indicated the investigator was unable to determine what object was involved or who the perpetrator was:		**Specific #2: Consumer #3 PS** Consumer #3 PS from Wyckoff Cottage was identified with unusual skin scratches on 3/28/2011 and was moved to another area in the facility for her protection. Appropriate treatment was provided for PS when identified. Based on the incident of 11/2/10 involving IB, the following measures were put in place: --PS was transferred from the cottage for her protection, staff from the cottage were not allowed to have any contact with the involved consumer. --Cottage rounds were increased by managerial staff. --After the subsequent incident of 3/28/11, an additional proactive measure was added to include managerial staff on site in the cottage. All above mentioned measures were kept in place until July, 2011, at which time there were no further incidents of this nature. The additional measures were re-started to ensure consumer protection that were put in place following the incident of 11/21/10, which included --Removing the consumer from Wyckoff cottage, Wyckoff staff were not allowed to have any contact with the removed consumer and --The Office of Investigation and the HSPD were informed and an investigation was initiated. --Employees that were suspected of being involved were immediately placed off	3/14/2012

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W 127	Continued From page 6 however, "Abuse is substantiated."		duty. --Employees who were cleared following the investigation were sent for retraining as deemed necessary. --In the cases where issues were identified that required corrective actions, although not an allegation of abuse, disciplinary action was issued.	
	3. According to a facility Investigative Report initiated 11/21/11, at 5:35 a.m. that same day, a caregiver reported findings scratches on Consumer #1's back when getting her dressed that morning. The Licensed Practical Nurse (LPN) on duty documented her observation of two scratches 13 cm in length, one scratch 18 cm. in length, and one scratch 17 cm in length. The Summary of Evidence indicated the consumer had diagnoses of PMR, Dysphagia, Hyperthyroidism, and Hypokalemia. The consumer is non-ambulatory and requires total assistance with all activities of daily living. All equipment utilized by the consumer was inspected, as well as her environment. None of the equipment was identified as a probable cause. An investigation conclusion substantiated abuse although the origin of the scratches and the "alleged perpetrator" were unknown. All concerns were addressed at an EIM meeting. On interview 2/06/12 at 10:30 a.m., the CEO stated that she is a part of the LIM and EIM meetings. When asked if there were any minutes from thee meetings that the surveyor could review, the CEO stated there were no formal minutes and that she "just jots things down."		**Specific #3: Consumer #1 SS** Consumer #1 SS from Wyckoff Cottage was identified with unusual skin scratches on 11/21/2011 and was moved to another area in the facility for her protection. Appropriate treatment was provided for IB when identified. Based on the incident of 11/2/10 involving IB, the following measures were put in place: --SS was transferred from the cottage for her protection. Staff from the cottage were not allowed to have any contact with the involved consumer. --Cottage rounds were increased by managerial staff. --After the subsequent incident of 3/29/11, an additional proactive measure was added to include managerial staff on site in the cottage. All above mentioned measures were kept in place until July, 2011, at which time there were no further incidents of this nature. The additional measures were re-started to ensure consumer protection following the incident of 11/21/11, which included --Removing the consumers from Wyckoff cottage, Wyckoff staff were not allowed to have any contact with the removed consumers and --Staff in question were placed off duty. --The office of Investigation and the HSPD were informed and an investigation was initiated. --Employees that were suspected of being involved were immediately placed off duty. --Employees who were cleared following the investigation were sent for retraining as deemed necessary. --In the cases where issues were	3/14/2012

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W 127	Continued From page 7 In an interview on 2/01/12 at 12:30 p.m., Investigator #1, who conducted the investigation on Consumer #2's injuries, stated that as part of the investigation, all incidents reports fro Wyckoff Cottage were pulled and reviewed. There were ten incident reports involving scratching injuries of unknown origin going back to January, 2010. These ten reports were reviewed by the Local Incident Management (LIM) team and deemed "non-reportable" and "filed away." The investigator then said that after the investigation was completed on consumer #2, the "consumer was moved to another cottage and increased supervisory rounds at Wyckoff Cottage were implemented." Also, Registered Nurses went and completed full body assessments at the cottage. In January of 2012, twice daily body assessments by two staff members were started. When asked if the investigator was aware of any other changes made to address these issues, she stated there is currently a number of staff off duty since this last incident. The investigator was then asked if any other cottages had reported any unusual scratches and she state, "No, it was only at Wyckoff." On 2/01/12 at 3:15 p.m., a tour of Wyckoff Cottage was conducted, accompanied by the Head Cottage Training Supervisor (HCTS). Consumers of Wyckoff Cottage were observed. All consumers were out of their rooms and in large common areas. No scratches were observed. No consumers observed were interviewable. When asked if she was aware of consumers having scratches of unknown origin, the HCTS stated she was. When asked if there was any way the consumers could have scratched themselves, she		identified that required corrective actions, although not an allegation of abuse, disciplinary action was issued. **I.D. Others** The facility practice of identifying all injuries and the documentation of same consumer on the IR-a forms. --All consumer injuries were immediately reported to the Duty Office to the Administrative Officer of the Day (AOD), which is staffed 24/7. The AODs were trained investigative initial responders. They respond on site and review all injuries. --The AOD and Cottage Supervisor implement client protections immediately as per Policy. Injuries are reviewed by cottage supervisors as part of the Local Incident Management Team daily. --All cottage IR-a reports were then reviewed by the Facility Incident Management Team (IMT) compromised of Quality Assurance and Duty Office staff several times a week. Unusual injuries were referred to the DHS Office of Program Integrity and Accountability for objective review and a determination if a full investigation was warranted. --Both Teams had been provided a general description of the unusual scratches under investigation with directions to critically review all marks to rule out a similar pattern and report to IRT immediately if identified. --Effective 3/6/2012 rounds in every cottage, with the exception of Wyckoff Cottage, are being provided twice per shift by the Duty Office staff, where consumers are present and/or sleeping to review the operation and to observe consumers for any signs of distress. Bath and Body records are being viewed daily by cottage supervisory staff and weekly by the Duty Office staff. Cottage supervisory staff are to document on the 24 hour report whenever a visitor enters the cottage. If suspicious injuries or activity are reported in a cottage, the AOD	3/14/2012

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W 127	Continued From page 8 replied, "Some scratch themselves-but not like that." The HCTS had observed Consumer #1's injury early in the morning when she began her shift. The scratches were "fresh and deep" When asked if any staff was currently off duty, she stated, "No, they were retrained and put back on duty." No further incidents had occurred since 11/21/11. On interview at 3:45 p.m., the Chief Executive Officer (CEO) was asked to outline what the facility had implemented to protect all of the consumers at Wyckoff Cottage since the initial formal investigation on 11/2/2010. The CEO indicated that additional supervisory rounds by duty officers and supervisors were initiated "when the issue was fir identified." The CEO added that in January, 2012, body checks were to be completed in the presence of two staff members, twice a day. On 2/06/12 at 10:20 a.m. and 4:00 p.m., the CEO was again asked about increased supervisory rounds hat were initiated after the 11/2/2010 investigation and if there were any changes made from that point until the most recent injury on 11/21/2011. Initially, the CEO stated she believed at one time the rounds were discontinued then restarted but that thee was no increase of thee rounds, "they would have just been maintained." On the latter 4:00 p.m. interview the CEO stated she was "mistaken" and the supervisory rounds were never discontinued. The only other intervention implemented was that on 1st and 2nd shifts, a two staff daily body assessment was initiated in January of this year. On 2/02/12 at 10:20 a.m., the CEO was asked to provide documentation of the additional supervisory rounds implement since November, 2010. The surveyor was provided an account of additional rounds from 3/2/2011 through 7/22/2011.		will initiate additional rounds immediately in the respective cottage, two additional rounds per shift for a total of four rounds for each shift. --All consumer injuries/incidents were reported to the Duty Office staff immediately. Duty Office staff were to report to the cottage to visually assess and evaluate injury in a timely manner. --The Duty Office staff continue to initiate investigations if necessary and ensure consumer protection at all times. **Systemic:** The Managers constituting the Governing Body directed that: --Consumers SS, PS and IB were transferred to another cottage at the conclusion of the investigation because the perpetrator could not be determined. --Additional rounds by the Duty Office/Unit Managers were implemented in Wyckoff Cottage when the issue was identified in 11/2010. --Effective 2/7/2012 cottage rounds were completed every two hours for a total of four times a shift in Wyckoff Cottage. Cottage rounds were completed two times per shift for all other residential cottages effective 3/6/2012. There will be a separate document for accountability which will be signed by the supervisor and counter signed by the manager on duty, which was implemented Although the enhanced rounds began 11/2010 when the injuries were found on consumer IB, a new form was implemented 02/09/12 for improved tracking and clarity. --The Administrative Officer of the Day completed tours through all areas where consumers were present and/or sleeping, documented any findings on comments section of form, also to observe consumers for any signs of distress. Additionally effective 3/6/2012 the AOD will review the bath and body records on site.	3/14/2012

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W 127	Continued From page 9 The CEO stated that documentation from November, 2010 through March 27, 2011 and documentation from July 21, 2011 to present was "probably in a box somewhere" and was not provided on day of survey, 2/06/12. Body assessment sheets for Wyckoff Cottage consumers were requested and reviewed for the months of January and February, 2012. Sixty-six of the ninety-five Bathing/Body Check Records reviewed had incomplete documentation regarding the two staff signatures required, as per the facility's corrective action plan. In an interview on 2/06/12 at 12:30 p.m., the Cottage Training Supervisor (CTS) on duty in Wyckoff Cottage stated that consumers are bathed daily and that two staff persons are to complete a body assessment on both the 1st an 2nd shifts. The CTS then stated that there had been some misunderstanding by staff about the how the checks were to be done because the form was different. She then added that "someone was working on it." A review of the facility's policy entitled Abuse/Neglect stated that facility responsibilities include, "If the accused is unknown, provide supervision for the consumer outside the area the incident occurred, until the AOD arrives." Also, the nurse shall, "Complete a full body check and document precisely describing any injuries found…." A Plan of correction for the immediate jeopardy to all consumers in Wyckoff Cottage was obtained on day of survey.		--The review of observations and completeness of the Bath and Body record will be documented. The observation form will include a list of observations. The form will be a monthly form and remain in the cottage to be retained in the Duty Office at the end of each month. --The Supervisor of Professional and Residential Services/Assistant (SPRS/A) will be responsible for completing rounds two times/shift during administrative hours, for Wyckoff Cottage for a total of four rounds/shift including the Duty Office AODs. Two rounds per shift will be completed in all other cottages by either the Duty Office AODs or the Section SPRS/A. All managers completing rounds will check that the additional rounds are being completed and the documentation is done ensuring correction on site. The documents will be reviewed periodically during the month by the CEO/designee. **Quality Assurance:** QA will monitor for compliance during on-site Active Treatment Audits in all cottages. Auditors will check for compliance of completed body check forms/practices at different times of the day. QA auditors are in the cottages daily during administrative hours completing random reviews to include this monitoring. --Areas of concern will be alerted immediately to the supervisor on duty, Duty Office and Unit Management for remediation. --Written findings will be sent to the Section Leader and Duty Office for formal responses and corrective action(s) taken. --Responses will be provided to the CEO/Quality Assurance Director for any further actions. QA reviews all incident reports and will monitor for trends and patterns of injuries. QA reports trends to the Risk Management Committee quarterly or	3/14/2012

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W 127	Continued From page 10		sooner when trends are identified. Effective 3/6/2012 the Duty Office AODs will complete random checks of the body checks being done in all cottages on site at least once a month. They are required to a complete body check during consumers' bathing time. They will document on a separate body check form that will be maintained in the Duty Office and document any findings and compare	
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: IMMEDIATE JEOPARDY Based on observation, interview and review of facility investigations and incident reports, it was determined that the facility failed to thoroughly investigate a documented pattern of injuries of unknown origin (skin scratchings/carvings) in Wyckoff Cottage occurring over a period of twenty-two months, involving eight of eleven consumers with similar injuries. (Consumers #4, 5, 6, 6, and *, and unsampled Consumers A, B, and C). This deficient practice is evidenced by the following: In an interview with the surveyor on 2/01/12 at 10:30 a.m., Investigator #1 stated that when and incident occurs, an incident report is immediately generated documenting the nature of the incident and immediate assessment and response by medical personnel. The incident report is then sent to the Local Incident Management (LIM) team for review. The reports are "passed out" to those in attendance for individual review. The person reviewing the report decides if the incident is "reportable" or "non-reportable." A reportable incident is sent for further investigation; a non-reportable incident "basically goes to file." A supervisor will sign off on the initial reviewer's decision. The current facility investigatory unit is no longer a part of the LIM meetings.	W 154	to the staff body check forms. Any discrepancies will be brought to the shift supervisor, Section Manager and retained in the Duty Office. Any trends will be referred to Executive Management for corrective actions and referral to other agencies if necessary. The Duty Office is responsible for maintaining all documentation involved in all investigations. The Duty Office tracks action plans of recommendations to be implemented and corrective actions through completion and documentation of all actions. #1, 2, 3, 4, 5, 6,7 and 8: IMMEDIATE JEOPARDY. Refer to Plan of Correction provided February 6, 2012 which was accepted as abatement of the deficiencies. Refer to W 127 Thorough investigation for details of additional corrective actions of Identification of Others, Systemic and Quality Assurance. The facility practice of identifying all injuries, documenting this information on the IR-a form, continues. All consumer injuries/incidents are reported to the Duty Office staff immediately. The Duty Office is staffed 24/7 and the trained investigative initial responders review all cases. The AODs had been provided descriptions of the scratches under review and had been directed to report any findings of a similar nature to the IRT Office immediately. That is how the two	3/14/2012

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W 154	Continued From page 11 When Investigator #1 first received notification of the incident reported on sampled Consumer #2 on 11/2/10, the investigator decided to pull all previous non-reportable incident reports for the 2010 year for review. The surveyor was provided with these reports and the following information was reported and documented as follows: 1. On 1/14/10, unsampled Consumer A was found with multiple (156 in number) superficial scratches on her left side ranging from 8 cm to 10 cm in length. 2.On 2/98/10, unsampled Consumer B was found with two scratches on her right upper back measuring six inches and 3 inches. 3.On 4/19/10, unsampled Consumer C was observed with three linear scratches, seven inches long, on her mid-back. 4.On 5/03/10, sampled Consumer #5 was found with four (eight inch) scratches on her right thigh. 5. On 5/04/10, sampled Consumer #8 was found with two "deep" scratches measuring 24 cm long and 18 cm long. 6. On 8/17/10, sampled Consumer #7 was found with a three inch elongated scratch and two "criss-cross" scratches four inches in length. 7.On 9/29/10, sampled Consumer #4 was found with four scratches measuring 23 cm, 13 cm, 22 cm, and 30 cm on her back. 8. On 10/29/10, sampled Consumer #6 was found with four scratches 16 cm each in length Investigator #1 then stated that she immediately went to Wyckoff Cottage to take pictures of any scratches still present on the above consumers. Photographs dated 11/03/10 of healing scars on Consumers #4, #5 and #6 were provided to the surveyor for observation 2/01/12.		additional victims were identified. --Client protection measures were taken immediately. --All injuries were reviewed by cottage supervisors as part of the Local Incident Management process daily. -- All cottage IR-a reports were then reviewed by the facility Incident Management Team compromised of Quality Assurance and Duty Office staff several times a week. --The Teams had been provided a description of the unusual scratches under investigation and the subject of these citations with the directive to critically review for similar marks. Each Team was to report similar findings to the IRT Office immediately. Unusual injuries were referred to the Department of Human Services Office of Program Integrity and Accountability and the HSPD, for objective review and a determination if a full investigation was warranted. Each Section Office continues to review all consumer injuries/incidents on a monthly basis to search for any potential trends/patterns of injury. Unusual patters/trends are immediately reported to the CEO, Duty Office and Quality Assurance for follow-up investigation. **<u>Systemic:</u>** The formal investigative process began with the review and assessment of injuries and allegations as described in the Specific and Identification of Others response. After a case had been determined to be in need of a full investigation it was referred to the local Investigation Response Team (IRT) which reports formally to the Office of Performance Improvement and Accountability in the Department of Human Services. This reporting structure was implemented January 1, 2011 under the direction of managers with extensive investigative backgrounds and experience to fully develop the investigators and the	3/14/2012

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W 154	Continuation From page 12 Observation of these photographs revealed the following; A. Consumer #4 whose initial injury occurred on 9/29/10 had visible scarring of a combination of two criss-cross marks and two linear marks still present on her back, five weeks after the injury. B.Consumer #5 whose initial injury occurred on a 5/03/10 had visible scarring of one criss-cross mark and two linear marks still present on her thigh six months after the injury. C.Consumer #6 whose initial injury occurred on 10/29/10 had multiple visible scratches in varying directions still present on her back. Investigator #1 went on to say that the eight incident reports reviewed by the surveyor (examples 1 through 8 listed above) were deemed "non-reportable" by the LIM committee, "not warranting further investigation." She added that "one of the problems identified was the lack of a better assessment and description of the wounds on the incident reports." When asked if any other cottages reported similar injuries the investigator stated that no other cottages were involved with these types of injuries. The consumers residing in Wyckoff Cottage are PMR and dependent on staff for all of their activities of daily living. Consumer #2 was the only ambulatory consumer in the cottage. Investigator #1 added that during the interviewing of all employees on that unit, a problem with accountability was evidenced. Caregivers had daily assignments but often provided care to others no assigned to them. It was difficult for the caregivers to remember if the consumers were dressed by them or a co-worker. A Plan of correction for the immediate jeopardy to all consumers in Wyckoff Cottage was obtained		process independent of the Developmental Centers. The following was implemented: --Beginning January 2011 all investigative staff were being trained on the new process and enhanced investigative procedures. During that time their skill sets were being evaluated. --All investigators and facility first responders were retrained in the basic requirements to begin an investigation competently of the Labor Relations Alternative (LRA). Their competence was formally assessed through the requirements to pass a final test, which all investigators assigned to VDC passed. This occurred in July of 2011, after the scratches/marks were identified on Consumer #2 and that case had been investigated and closed by IRT and the Human Services Police as an accidental injury. --Most of the IRT investigators were sent for formal investigative training through a cooperative effort with the Division of Criminal Justice and the Office of Investigations. The training was off-site in Sea Girt, New Jersey in June 2011. The training was on the investigative process from interview through providing testimony. This training occurred after the incident involving Consumer #2 was identified and those with what Investigator #1 described as "similar" scratches. Additional training was provided to all investigators on May 17, 2011. Two blocks of instruction were covered: Interviewing and Investigation and Investigation Report Writing. --The investigators meet with facility managers several times weekly to provide updates and/or closure of cases within the required five-day requirement. --Compliance to actions recommended at the conclusion of each case requiring an action plan is tracked through the facility Duty Office.	3/14/2012

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	31G006	A. BUILDING _____ B. WING _____	2/6/2012

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	on day of survey. Continuation From page 13			
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Cross Reference W 154 IMMEDIATE JEOPARDY Based on observation, interview and review of facility incident reports, investigations and medical records, it was determined that the facility failed to implement appropriate measures to monitor staff and consumers in Wyckoff Cottage to prevent ongoing incidents of injuries of unknown origin (skin scratching/carvings) from the initial incident report on Consumer A dated 1/14/10 through the last incident report dated 11/21/11, a period of twenty-two months. This deficient practice is evidence by the following: See all examples. A Plan of Correction for the immediate jeopardy to all consumers in Wyckoff Cottage was obtained on day of survey.	W 155	**Quality Assurance:** Effective 2/13/2012 QA monitors for compliance during on-site Active Treatment Audits in all cottages. Auditors check for compliance of revised body check forms/practices at different times of the day. Auditors also review the supervisory rounds form for compliance. Areas of concern are reported immediately to the supervisor on duty, Duty Office and Unit Management for remediation. Written findings are sent to the Section Leader and Duty Office for formal responses and corrective action(s) taken. Responses will be shared with CEO/Quality Assurance. QA staff review all Unusual Incident Reports and full investigative reports as a quality assurance review when they are received. Areas of concern are reported to the CEO and Lead Investigator immediately for intervention as needed. Trends and patterns are also referred and reviewed by the facility Unusual Incident Committee and Risk Management Committee. IMMEDIATE JEOPARDY: Refer to Plan of Correction provided February 6, 2012 which was accepted as abatement of the deficiencies.	3/14/2012
W 157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. This STANDARD is not met as evidenced by: Based on observation, interview and review of facility incident reports, investigations and medical records, it was determined that the facility failed to implement appropriate corrective actin, over a period of twenty-two months, to assure that further injuries of unknown origin (skin scratchings/carvings) in Wyckoff Cottage would not occur. This deficient practice is evidenced by the following:	W 157	Refer to W 127 for details of additional corrective actions of Identification of Others, Systemic and Quality Assurance. **Specific**: When an alleged violation was verified, the following was implemented: Consumers from Wyckoff Cottage identified with unusual skin scratches were moved to other appropriate cottages. Appropriate treatment was provided for all the involved consumers. --Based on the incident of 11/2/10, the following measures were put in place: involved consumers were removed from the cottage for their protection, staff from the cottage were not allowed to have any contact with the involved consumers and cottage rounds were increased by managerial staff.	3/14/2012

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W 157	Continuation From page 14 In an interview with the surveyor on 2/01/12 at 12:30 p.m., Investigator #1 stated that after the first validated abuse investigation related to Consumer #2's injuries, the facility identified a need for increased supervision in Wyckoff Cottage. Additional rounds by supervisors were implemented and Consumer #2 was eventually moved to another cottage. After the second validated abuse investigation regarding Consumer #3's injuries, the investigator was aware of no modifications or additional interventions that were put in place to prevent another occurrence, only that Consumer #3 was also moved to another cottage. After the third validated abuse investigation regarding Consumer #1's injuries, the facility moved Consumer #1 to another cottage and implemented twice daily body checks in the presence of two staff persons for remaining consumers. Investigator #1 state that as a result of the last investigation completed on 11/13/11, four direct caregivers were placed off duty for procedural reason; however, were not identified as the perpetrator. On 2/06/12 at 10:20 a.m. and 4:00 p.m., the CEO stated that increased supervisory rounds were started after the first validated abuse investigation in November, 2010. The CEO then stated there was no set schedule for the increased rounds. When asked if there was any modification to this intervention after the second incident of abused was validated, the CEO said, "No, they would have just been maintained." The CEO was then asked to provided documentation of the increased supervisory rounds. A record given to the surveyor for review indicated various rounds were made to Wyckoff Cottage on different shifts from 3/28/11 through 7/21/11. No records prior to 3/28/11 or after 7/21/11 were available on 23/06/12, the last day of survey.	W 157	--After the subsequent incident of 3/29/11, an additional proactive measure was added to include managerial staff on site in the cottage. All above mentioned measures were kept in place until July, 2011, at which time there were no further incidents of this nature. --The additional measures were re-started to ensure consumer protection following the incident of 11/21/11, which included removing the consumers from Wyckoff cottage. --The Office of Investigations and the HSPD were informed and an investigation was initiated. Employees that were suspected of being involved were immediately placed off duty. --Employees who were cleared following the investigation were sent fro retraining and deemed necessary. In the cases where issues were identified that required corrective actions, although not allegation of abuse, disciplinary action was issued. **I.D. Others** The facility practice of identifying all injuries and the documentation of same consumer on the IR-a forms continues. --All consumer injuries were immediately reported to the Duty Office to the Administrative Officer of the Day (AOD), which is staffed 24/7. The AODs were trained investigative initial responders. They respond on site and review all injuries. --The AOD and Cottage Supervisor implement client protections immediately as per Policy. Injuries were reviewed by cottage supervisors as part of the Local Incident Management Team daily. --All cottage IR-a reports were then reviewed by the Facility Incident Management Team (IMT) compromised of Quality Assurance and Duty Office staff several times a week. Unusual injuries were referred to the DHS Office of Program Integrity and Accountability for objective review and a determination if a full investigation was warranted. --Both Teams had been provided a general description of the unusual scratches under investigation with directions to critically review all marks to rule out a similar pattern and report to IRT immediately if identified. --Effective 3/6/2012, rounds in every cottage with the exception of Wyckoff Cottage, are provided twice per shift by the Duty Office staff, where consumers are present and/or sleeping to review the operation and to observe consumers for any signs of distress. Rounds are being provided four times per shift in Wyckoff Cottage. Bath and Body records are to be viewed daily by cottage supervisory staff and weekly by the Duty Office staff. Cottage supervisory staff are to document on the 24 hour report whenever a visitor enters the cottage. If suspicious injuries or activity are reported in a cottage, the AOD will initiate additional rounds immediately in the respective cottage, an increase of two additional rounds per shift for a total of four rounds	3/14/2012

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			per shift. --All consumer injuries/incidents were reported to the Duty Office staff immediately. Duty Office staff were to report to the cottage to visually assess and evaluate injury in a timely manner. --The Duty Office staff will initiate the investigation if necessary and ensure consumer protection at all times. **Systemic:** To ensure that treatment of consumers by staff was appropriate the following was implemented: --Consumers SS, PS and IB were transferred to another cottage at the conclusion of the investigation because the perpetrator could not be determined. --Additional rounds by the Duty Office/Unit Managers were implemented in Wyckoff Cottage when the issue was identified in 11/2010. --Effective 3/6/2012 cottage rounds were completed every two hours for a total of four times a shift. There will be a separate document for accountability which will be signed by the supervisor and counter signed by the manager on duty, which was implemented The enhanced rounds began 11/2010 initially when the injuries were found on consumer IB. A new form was implemented 02/09/12 for improved tracking and clarity. --Effective 3/6/2012 the Administrative Officer of the Day completed tours through all areas where consumers were present and/or sleeping, documented any findings on comments section of form, also to observe consumers for any signs of distress. Additionally the AOD reviews the bath and body records on site. --The review of observations and completeness of the Bath and Body record is documented. The observation form includes a list of observations. The form will be a monthly form and remain in the cottage to be retained in the Duty Office at the end of each month. --The Supervisor of Professional and Residential Services/Assistant will be responsible for completing rounds two times/shift during administrative hours for Wyckoff Cottage for a total of four rounds per shift including the Duty Office AODs. Two rounds per shift will be completed in all other cottages by either the Duty Office AODs or the Section SPRS/As. All managers completing rounds will check that the additional rounds are being completed and the documentation is done ensuring correction on site. The documents will be reviewed periodically during the month by the CEO/designee. **Quality Assurance:** Effective 2/13/2012 QA will monitor for compliance during on-site Active Treatment Audits in all cottages. Auditors will check for compliance of completed body check forms/practices at different times of the day. QA auditors are in the cottages daily during administrative hours completing random reviews to include this monitoring. --Areas of concern will be alerted immediately to the supervisor on duty, Duty Office and Unit Management	3/14/2012

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			for remediation. --Written findings will be sent to the Section Leader and Duty Office for formal responses and corrective action(s) taken. --Responses will be provided to the CEO/Quality Assurance Director for any further actions. QA reviews all incident reports and will monitor for trends and patterns of injuries. QA reports trends to the Risk Management Committee quarterly or sooner when trends are identified. The Duty Office AODs will complete random checks of the body checks being done in all cottages on site at least once a month. They are required to a complete body check during consumers' bathing time. They will document on a separate body check form that will be maintained in the Duty Office and document any findings and compare to the staff body check forms. Any discrepancies will be brought to the shift supervisor, Section Manager and retained in the Duty Office. Any repeated trends will be referred to Executive Management for corrective actions. The Duty Office is responsible for maintaining all documentation involved in all investigations. The Duty Office tracks action plans of recommendations to be implemented and corrective actions through completion and documentation of all actions.	3/14/2012

CONFIDENTIAL, ADVISORY DELIBERATIVE MATERIAL

SUBSTANTIATED INCIDENTS

January 1, 2011 thru February 13, 2012

DHS INVESTIGATIVE UNIT	FACILITY	Average Census	Number of Substantiated Incidents of Abuse		Number of Substantiated Incidents of Neglect		Number of Substantiated Incidents of Exploitation	
			Total Substantiated Incidents	Percent of Substantiated Incidents	Total Substantiated Incidents	Percent of Substantiated Incidents	Total Substantiated Incidents	Percent of Substantiated Incidents
	GBRC	100	0	0%	0	0%	0	0%
	HDC	532	8	1.5%	2	0.4%	0	0%
	NJDC	380	15	3.9%	8	2.1%	0	0%
	NLDC	414	18	4.3%	28	6.8%	2	0.5%
	VDC	333	13	3.9%	12	3.6%	3	0.9%
	WDC	462	10	2.2%	5	1.1%	2	0.4%
	WDBR	354	6	1.7%	7	2.0%	1	0.3%

In January 2011, the Investigative Units that were under the supervision of the developmental center Chief Executive Officers were centralized at the Department of Human Services and placed under the Office of Program Integrity.

CONFIDENTIAL, ADVISORY DELIBERATIVE MATERIAL

Overview of New Jersey's Developmental Centers

Statistics as of 3/31/12

Name of Facility	Location and Proximity to Nearest DC	Description of Campus	Number of Individuals Served Effective 3/31/12	Description of Individuals Served	Operational Needs of the Department Mitigating Factors	Number of Full Time DC Staff Effective 4/30/12	Number of Staff Eligible for Retirement
Green Brook Regional Center (GBRC)	Busy Suburban area in Green Brook, NJ.	Single standing building with 2 residential floors on 26 acres of land	101	Age 55+ Fragile	Programs are geared to geriatric population	247	12
	18 miles to Woodbridge			Medical needs typical of geriatric	Few facility infrastructure needs.		
					All bedrooms have a private bathroom.		
Hunterdon Developmental Center (HDC)	Rural area outside of Clinton, NJ. 26 miles to Green Brook	29 buildings, 18 are residential along with 3 residential units in the Health Service building; on 102 acres of land	524	53% are non ambulatory	Least number of individuals wanting to move to the community.	1,436	68
					Can accommodate individuals with trachs and ventilators. Oxygen system upgrade in the design phase		
					Extensive fine arts programs.		
					Co-generation with Edna Mahon Correctional Facility		
					High temperature/hot water system involving pipelines for natural gas and individual boilers and hot water heaters for each building being installed next year		
New Lisbon Developmental Center (NLDC)	Rural area on the edge of the South Jersey Pinelands.	58 buildings, 16 are residential, on 1,896 acres of land	407	85% are males	MSU located on grounds which offers a secure placement for individuals with legal/criminal involvement.	1,431	48
	60 miles to Vineland			81% are ambulatory	New Lisbon also has two "Step Down" units that house many hard to place individuals due to their criminal history.		
					Received Federal Stimulus dollars for Energy Saving Projects.		
					natural gas lines and 40 new boilers and hot water heaters for each building installed.		
					23 buildings had new roof insulation		
					2 new generators, 1 new transformer and 2 new chillers were installed		
					Energy saving internal lighting was installed		
					New air conditioning in Community Center		

North Jersey Developmental Center (NJDC)	Busy suburban area in Totowa, NJ. 28 miles to Woodbridge	35 buildings, 11 are residential, on 188 acres of land. Eight residential buildings are two story buildings.	363	80% are ambulatory	NJDC has the capacity to house juveniles who have been determined to have an intellectual disability and who have legal/court involvement in an unlocked, 6 bed, Special Support Unit (SSU). This unit is used only minimally at this point and the fact that DDD no longer serves children has eliminated the need for the SSU. Two story residential units pose safety concerns.	1,003	74
Vineland Developmental Center (VDC)	Rural area in Vineland, NJ. 26 miles to Woodbine	33 buildings, 10 are residential, on 167 acres of land	311	41% are ambulatory	VDC serves only women New roofs on 4 of 7 residential units completed 6/2012 DC is in the county with the highest unemployment rate in the State	1,152	95
Woodbine Developmental Center (WDC)	Rural area in Woodbine, NJ. 26 miles to Vineland	41 buildings, 17 are residential, on 250 acres of land	456	67% are ambulatory	WDC serves only men. Extensive Learning Center and Horticulture Program. Three new boilers have been installed that use natural gas Burns methane gas decreasing the carbon footprint for the county. New underground steam lines installed New roof and HVAC system for the administration building completed. Designated Evacuation Site for Cape May County and designated Point of Delivery (POD) for mass inoculation and supply distribution in National Security emergencies.	1,332	46
Woodbridge Developmental Center (WDBR)	Busy suburban area in Woodbridge, NJ. 18 miles to Green Brook	25 buildings, 16 are residential, on 68 acres of land	341	63% are non ambulatory. Majority have physical and nutritional needs.	Can accommodate individuals with medical issues. Provide steam for heat and hot water at Rahway Prison and the Ann Klein Forensic Administration Offices	1,246	75

DC Infrastructure in Millions of Dollars

Figures Based on FY 2013 - FY15 DDD Capital Budget Request (000's)

	IDENTIFIED PROJECTS	GBRC	HDC	NLDC	NJDC	VDC*	WDC	WDBR
DC INFRASTRUCTURE NEEDS	HVAC	$0.75	$8.00		$0.85	$5.00	$5.20	$8.50
	Emergency Generator				$1.50			
	Steam Condensation Dist. System				$4.65			$5.50
	Roofs	$1.50	$2.06	$1.06	$0.50	$1.20	$1.06	$1.50
	Kitchen Renovations	$1.50			$1.50			
	ADA Bathroom Reno.				$3.38	$2.50		$3.38
	Water Supply (wells, towers, distribution)		$0.50					$0.75
	Demolition of Vacant Bldg			$0.75				
	Power House						$1.50	
	Hot Water Generation				$1.00			
	Domestic Water Safety					$1.20		
	Electrical Upgrades				$1.80	$1.95	$1.15	
	WWTP/Sewer System Improvements		$1.00				$3.00	
	Elevator Replacement				$0.50	$1.50		$0.60
	Asbestos Abatement		$0.75		$0.75	$0.50		$0.75
	Various Preservation Projects	$1.89	$4.70		$5.46	$4.00		
	Flooring							$1.20
	ADA Modifications					$0.08		
	Storm Water Management				$1.20	$0.45	$0.80	
	NJDEP Remediation Projects						$0.50	$0.30
	Exterior Lighting					$0.75		
	Replace Fire Escapes					$1.00		
	Door Panic Hardware					$1.00		
	TOTALS	$5.64	$17.01	$1.81	$23.09	$21.13	$13.21	$22.48

***VDCs figures are based upon FY 2012 DHS Capitol Budget Request since they were not included in the FY2013 Request.**